unit (ICU) support cures any disease."[2] He agreed that ICU support can reduce the immediate risk of death in certain acute illnesses, and that it is valuable in burn cases. "But ICUs also make it possible to prolong the dying process. It is essential, therefore, to acknowledge an absolute limit to intensive care if we are to improve its use."

Who among us will have the courage to set down firm criteria for admission to an ICU?

This again brings us back to the issue of cost containment. Knowing that the use of respiratory therapy, CCUs and ICUs accounts for well over 1% of our gross national product, will I be able to curtail my appetite for these costly ancillary services or will I wait for Uncle Sam to put me on a diet? Will we physicians continue to make these decisions or will they be made for us by government appointed committees?

We are faced with this choice: Make a conscientious and consistent effort to use these costly services only when the absolute indication exists or be ready to have them limited for us. This can be our individual effort in our everyday practice. It will not be easy. We find it difficult to cut back on the full benefits of care our patients have learned to expect.

Even more difficult for us will it be to accept the fact that we need strong negotiators to represent us in Washington, DC. As physicians we have been reluctant to give up our individuality. Efforts to unionize us have failed. In spite of this, and not always with full support from physicians, the health care industry (as the practice of medicine is referred to in Congress) has had capable negotiators at work in the nation's capital. The vigorous efforts exerted by the American Medical Association in our behalf have not always been given the credit due them.

We in medical practice must realize that we are facing changing economic realities—it is no longer "business as usual." Our leaders who represent us at the bargaining table are aware of this. But they need negotiating tools. We can lend strength to these tools by asserting a readiness to trim some of the fat from our health care diet, while protecting a lean and healthy patient care program.

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Physicians and Boxing

TO THE EDITOR: The medical profession has been advocating the banning of boxing in the recent past because of some of the injuries incurred. Boxing will never be banned because if an attempt was made one could expect it to go underground.

Way back in the 1960s when I introduced the concept that a fighter could not be "saved by the bell" for obvious reasons, I also suggested that the medical profession become more involved in the sport to help it.

We can do a lot to minimize the injuries incurred in boxing if we can interest both neurologists and neurosurgeons in becoming seriously involved in the sport. We need more of those disciplines both as ring physicians and referees. If we could have these physicians acting as referees, we could add considerably to the sport's safety for they would recognize more problems than nonmedical referees. Let's put our mouths where our knowledge is.

One does not have to be a boxer to be a referee. The rudiments of the sport can be quickly learned from ring professionals and trainers, so this argument can be quickly forgotten. Remember, one of the finest football coaches and boxing coaches of all time was the eminent Dr John Bain Sutherland of the University of Pittsburgh. He neither played football nor boxed—and his accomplishments are legion.

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